STATE OF MAINE
DIRIGO HEALTH AGENCY

IN RE:	)	
REVIEW OF AGGREGATE	)	**REPLY BRIEF OF**
MEASURABLE COST SAVINGS	)	**CONSUMERS FOR AFFORDABLE**
DETERMINED BY DIRIGO HEALTH	)	**HEALTH CARE**
FOR THE SECOND ASSESSMENT YEAR	)	
(2006)	)	

Intervenor Consumers for Affordable Health Care ("CAHC") submits its Reply Brief in accordance with the Superintendent's Notice of Pending Proceeding and Hearing dated April 26, 2006, the Orders on Intervention and Procedures dated June 15, 2006 and the Order on Motions dated June 26, 2006.

INTRODUCTION

ARGUMENT

I. CAHC AGREES WITH DHA's INTERPRETATION OF THE STATUTE; AMCS IS NOT LIMITED TO REDUCTION OR AVOIDANCE OF BAD DEBT AND CHARITY CARE

II. WITH THE EXCEPTION OF THE BOARD's USE OF THE MEDIAN TO DETERMINE THE CMAD, THE BOARD's DETERMINATION OF AMCS IS REASONABLE AND SUPPORTED BY SUBSTANTIAL EVIDENCE IN THE RECORD

A. It Was Reasonable and Supported by Substantial Evidence in the Record for the DHA Board to Include CMAD in Its Second Year Determination of AMCS

B. It Was Not Reasonable for the DHA Board to Use the Median Rather Than the Geometric Mean To Determine the CMAD

C. CAHC Agrees With DHA That Payor Intervenors' Assertion That There Were No Savings From CMAD Is Fatally Flawed

D. The DHA Board's Determination of Uninsured Savings Initiatives Was Reasonable and Supported by Substantial Evidence in the Record

E. The DHA Board's Determination of CON/CIF Was Reasonable and Supported by Substantial Evidence in the Record

CONCLUSION

INTRODUCTION

The Dirigo Health Act, P.L. 2003, Ch. 469, as amended by P.L. 2005, Ch. 400 (the Act"), established the Board to arrange for the provision of health coverage for Maine citizens with subsidies coming from annual assessments on insurers and third party administrators based on cost savings determined by the Board and approved by the Superintendent from initiatives to reduce costs in the health care system. In accordance with 24-A M.R.S.A. §6913, sub-§1, ¶A, the Dirigo Health Agency Board determined the second year's cost savings at $41,757,000 after an adjudicatory proceeding conducted by Board and administered by an independent hearing officer. The Maine Legislature gave the Board "all powers necessary to or convenient to effect the purposes for which Dirigo Health is organized or to further the activities in which Dirigo Health may lawfully by engaged, including the establishment of the Dirigo Health Program." 24-A M.R.S.A. §6908, sub-§1, ¶C.

ARGUMENT

I. CAHC AGREES WITH DHA's INTERPRETATION OF THE STATUTE; AMCS IS NOT LIMITED OR RESTRICTED TO REDUCTION OR AVOIDANCE OF BAD DEBT AND CHARITY CARE

At the core of the mandate to the Board is the provision that it make a determination annually as to:

> the aggregate measurable cost savings in this State, including any reduction or avoidance of bad debt and charity care cost to health care providers as a result of the operation of Dirigo Health and any increased MaineCare enrollment due to an expansion in MaineCare eligibility occurring after June 30, 2004. 24-A M.R.S.A. §6913(1)

CAHC agrees with the argument made by the Dirigo Health Agency in section II of its brief that this statutory provision is unambiguous. The Board is charged with the responsibility of calculating "aggregate measurable cost savings" in this State, period. It is not limited to bad debt and charity care or increases in the enrollment of MaineCare just because the Legislature chose to mention

these two measures in the statute. All the words after "*including any*" in the statute are simply examples or illustrations of the kind of costs savings to be measured, but not an exclusive list.

In their briefs, Anthem, the Chamber, the Autodealers and the MeAHP premised their interpretation of the above section of the statute on two alternative assumptions, both of which are erroneous. The first is that the word "including" should be read as "meaning" so that all the words after "including" constitute an exclusive list of what may be considered in the calculation of "aggregate measurable cost savings." The Law Court has squarely rejected this exact argument. It has held that the plain meaning of the word "includes" is to provide an example or illustration, not an exclusive list. In the case of *S.D. Warren Co. v. Board of Environmental Protection, supra*[1] the Law Court interpreted the meaning of the word "includes" as used in the definition of "discharge" in the federal Clean Water Act. The Court stated that it would be guided by the plain, common and ordinary meaning of statutory language to effect legislative intent. Id., 868 A. 2d at 216. Then it ruled that the "common definition of the word *includes* does not suggest it is a word of limitation," citing in support the Supreme Court case of *Helvering v. Morgan's Inc*., 293 U.S. 121, 125-6 (1934)("the verb 'includes' imports a general class, some of whose particular instances are those specified in the definition.") Other courts have come to the same conclusion. S*ee*, *Chickasaw Nation v. United States*, 534 U.S. 84, 89 (2001)(the plain, dictionary meaning of "including" is to comprise part of a whole, meaning to be illustrative); *United States v. Whiting*, 165 F.3d 631, 633 (8th Cir. 1999)("When a statute uses the word 'includes' rather than 'means' in defining a term, it does not imply that items not listed fall outside the definition."); *Oregon Natural Desert Association v. Thomas*, 940 F.Supp. 1534, 1540 (D. Or. 1996) ("The term 'including' in the discharge definition permits additional, unstated meanings."); *State of Maryland v. Wiegmann*, 714 A.2d 841, 845 (Md. Ct. App. 1998) (Ordinarily the word "including" means comprising by illustration and not by way of limitation.); and *Attorney General v. Huron County Road Comm*., 538 N.W.2d 68, 72 (Mich. Ct.

[1] The statutory phrase at issue was: "the term 'discharge' when used without qualification includes a discharge of a pollutant and a discharge of pollutants".

App. 1995) (the plain dictionary meaning of the word "includes" means to give examples that are not exclusive).

The second alternative theory erroneously assumes that the phrase "as a result of the operation of Dirigo" modifies "aggregate measurable cost savings," rather than the phrase "any reduction or avoidance of bad debt and charity care cost to health care providers." Their reading of the statute depends upon the insertion of a comma after the word "providers" so that the dependent clause -- "including any reduction or avoidance of bad debt and charity care cost to health care providers" – can be elided out and the provision would read "aggregate measurable cost savings in this State … as a result of the operation of Dirigo Health …" However, the comma giving this meaning is simply not there. The Maine Legislative Drafting Manual and rules of grammar support the Board's interpretation that the clause beginning with the words "including any" is non-restrictive and in no way limits or restricts "aggregate measurable cost savings." The Maine Legislative Drafting Manual states:

> Commas are probably the most misused and misunderstood punctuation marks in legal drafting and, perhaps, the English language. Use them thoughtfully and sparingly.
>
> **(c)** Clauses or phrases that are nonrestrictive, that is, parenthetical in nature, are set off by commas.
>
> **Examples:**
>
> The commissioner, appointed as provided in section 2333, may adopt necessary rules.
>
> The rules, which the commissioner is authorized to adopt under section 2332, must be adopted before September 1, 1992.
>
> **(3) Restrictive clauses.** Do not use commas to set off restrictive clauses or phrases that are essential to the meaning of the sentence.
>
> **Examples:**
>
> Any agency that is within the Department of Administrative and Financial Services shall report all purchases to the commissioner.

> The commissioner shall notify all applicants meeting the following qualifications of the department's actions.
>
> *Maine Legislative Drafting Manual*, Part III, Chapter 4, Section 2, Commas at http://janus.state.me.us/legis/ros/manual/Webdman-15.htm#P3967_234453

It is assumed that the Revisor of Statutes, whose office produced the legislative drafting manual and who is charged with drafting legislation for legislative committees, followed their own drafting rules. Those rules make abundantly clear that the interpretation by the Dirigo Health Agency Board is correct. Finally, the interpretation of the DHA Board that AMCS is not limited or restricted to bad debt or charity care is also supported by the rules of grammar. The Chicago Manual of Style states:

> "If a dependent clause is restrictive -- that is, if it cannot be omitted without altering the meaning of the main clause -- it should not be set off by commas. If it is nonrestrictive, it should be set off by commas."
>
> The Chicago Manual of Style, 5.34 (14th ed. 1993)

The Superintendent's statutory authority limits him to determining whether there is reasonable support in the record for the Board's determination. 24-A M.R.S.A. §6913, sub-§1, ¶C The Maine Legislature provided the Board with ample authority to make their determination, 24-A M.R.S.A. §6908, sub-§1, ¶C and that determination is due significant deference on review.

II. WITH THE EXCEPTION OF THE BOARD's USE OF THE MEDIAN TO DETERMINE THE CMAD, THE BOARD's DETERMINATION OF AMCS IS REASONABLE AND SUPPORTED BY SUBSTANTIAL EVIDENCE IN THE RECORD

A. It Was Reasonable and Supported by Substantial Evidence in the Record for the DHA Board to Include CMAD in Its Second Year Determination of AMCS

The Board and the Intervenors both point to the testimony of Steven Michaud, President of the Maine Hospital Association (MHA) in support of their arguments regarding the reasonableness of including CMAD in the aggregate measurable cost savings. The Board correctly noted that the

savings resulting from CMAD was related to the Dirigo Health Act despite the absence of express statutory language.

Contrary to the Intervenors' assertions, the record supports the Board's determination that savings resulting from CMAD are applicable to the second assessment year.[2] The caps expressly established by the Dirigo Health Act for the first assessment year were voluntary. Voluntary caps are just that – voluntary – and not enforceable regardless of whether they appear in statute or not. During cross-examination of Mr. Michaud by Mr. Comart, Mr. Michaud agreed that voluntary caps included in legislation were not binding:

> Q: What I don't understand is were you part of the negotiations regarding putting a voluntary target in legislation?
>
> A: Yes.
>
> Q: And is the voluntary target in legislation binding on any of the hospitals?
>
> A: No.
>
> Q: So it doesn't matter whether you have legislation or not for a voluntary target, right? It's not binding?
>
> A: Correct. I mean so I guess what you're asking in year 1 would we have been bound – I guess you're not bound by anything voluntarily. Would we have complied with the voluntary cap year 1 absent Dirigo, no.

R. 5149. Accordingly, the fact that the voluntary cap established by the Maine Hospital Association (MHA) for the second assessment year did not appear in statute is not in or of itself sufficient evidence to conclude that CMAD savings should not be included in the AMCS.

The MHA documents admitted into evidence during Ms. Turner's cross-examination of Mr. Michaud reveal that the MHA has consistently stated since 2004 that the MHA supports the goals of

[2] The Intervenors assert that the counsel for DHA acknowledged that CMAD did not apply to the second year assessment. The Intervenors' authority for this statement is not an opinion letter written by counsel but rather a handwritten note made by a Mercer employee, which was written in the early stages of the development of this case. The testimony of Steven Michaud, President of the Maine Hospital Association and evidence admitted into the record by the DHA attorney during the adjudicatory hearing contradicts this statement.

Dirigo Health and that MHA and the State should work collaboratively rather than the State mandating cost containment in the form of hospital caps. R. 1290. In 2005, CEO of Mayo Regional Hospital, Ralph Gabarro, in testimony delivered to the Hospital Study Commission, on behalf of the MHA, stated that the MHA supported "several key concepts" of the Hospital Commission Report, which was created as a result of the Dirigo Health Act, and that in MHA's view "many of these areas are both integral parts of Dirigo and current ongoing hospital/healthcare efforts and do not need further legislative action or additional state oversight." R. 1293. One of the areas expressly listed in Mr. Gabarro's testimony is "voluntary cost and margin targets." R. 1293. Again in 2005, the MHA in a document entitled, "Pointing the Way," the MHA included in its agenda that it would "[v]oluntarily comply with cost increase targets and margins targets and propose verification through an independent group of stakeholders" R. 1320, and "[s]upport the goals of Maine's DirigoChoice plan," R. 1322. There are additional MHA documents from 2005 and 2006 that reinforce the MHA's commitment to "continue efforts to comply with negotiated voluntary margins and cost increase targets." R. 1346, 1366, 1372. These documents reveal that the MHA collaborated with the State to continue the cost savings efforts defined in the Dirigo Health Act, rather than have mandatory caps dictated by statute. *See*, *e.g.* R. 1293, 1366, 1346.

The testimony of Mr. Michaud during cross-examination by Mr. Comart, illustrate that *but for* Dirigo the MHA would not have set or met the targets for 2004. In 2005, despite the absence of "statutorily dictated" voluntary targets, the MHA continued to adhere to voluntary targets as it was preferable to mandatory caps. The fact that the caps continue for years 2006-2008 further evidences that but for Dirigo Health, voluntary caps would not have been established. Therefore, the Board's decision to include CMAD in AMCS is reasonably supported by the record.

B. It Was Not Reasonable for the DHA Board to Use the Median Rather Than the Geometric Mean To Determine the CMAD

DHA's brief does not address CAHC's argument that the median (4.7%) was unreasonable in its measure of the rate of growth in CMAD. See Footnote 1, Brief of Dirigo Health, Introduction,

p. 2 Despite the Superintendent's ruling on the submission of additional evidence, the legal arguments made in CAHC's Intervenor Brief stand on their own, support a finding that the use of the median was not reasonable nor supported by substantial evidence in the record, and will not be repeated here. The document produced by Mercer under a Freedom of Access Act request, provided a Table (Table 2) that provides factual support to CAHC's assertion: the use of the median rather than the geometric mean was unreasonable and not supported by substantial evidence in the record. Of course, the Superintendent can take official notice of the Exhibit 1 to CAHC's Request for Leave to Submit Additional Evidence.

Table 2. Mean vs. Median: Projecting CMAD Forward

	Arithmetic Mean	**Geometric Mean**	**Median**
Calculation	Add the 3 annual percentage increases and divide by 3. (4.72+10.12+3.32)/3	Take the cube root of the 3 annual growth factors. Subtract 1 to convert to a percentage increase. $(1.0472 \times 1.1012 \times 1.0332)^{1/3}$ -100%	Determine which of the 3 percentage increases is where half the values are above and half are below. 10.12 High 4.72 Midpoint 3.32 Low
Result	6.05%	6.01%	4.72%
Role	Tells what the average rate of increase was from 2000 to 2003	Tells the actual compound annual rate of increase from 2000 to 2003	Tells the relative distribution of each of the three years' percentage increase
CMAD Predictive Value for 2003	$\$4,868 \times (1.0605)^3 = \$5,806$	$\$4,868 \times (1.0601)^3 = \$5,800$	$\$4,868 \times (1.0472)^3 = \$5,590$
CMAD Actual 2003	$5,800	$5,800	$5,800
Difference	($6)	$0	$210
Conclusion	The arithmetic mean, based on the actual values, is an excellent predictor of the CMAD actual value for 2003, with an error of only $6	The geometric mean, based on the actual values, exactly predicts the CMAD actual value for 2003, with no error ($0).	The median, which looks only at the relative distribution of the values, is an extremely poor predictor of the CMAD actual value for 2003, with an error of $210.
Bottom Line	The error using the median is on the order of magnitude of the annual variations in CMAD and so clearly illustrates the inappropriateness of the using the median.		

C. CAHC Agrees With DHA That Payor Intervenors' Assertion That There Were No Savings From CMAD Is Fatally Flawed

CAHC agrees with the position expressed in the last two sentences on page 10 of the DHA brief. The following clarification and elaboration of the DHA position graphically demonstrates the fatal flaw in the Payor Intervenors argument that Dirigo could never have produced savings in any year in which health care costs increased more than was expected for that particular year. (See page 8-10 of the Anthem Brief and pages 22-23 of the AHP Brief).

Suppose that total actual health care costs were $100 million before Dirigo took effect, and were expected to increase by $30 million each year for the next three years. However, due to the newly implemented Dirigo costs savings initiatives, total health care costs actually increased by $15 million in the 1st year, $15 million in the 2nd year, and $40 million in the 3rd year. A graphic representation of the above follows:

	Year 1	**Year 2**	**Year 3**	**3 Year Total**
Total expected health care costs	$130M	$160M	$190M	$480M
Total actual health care costs	$115M	$130M	$170M	$415M
Actual cost savings	$ 15M	$ 30M	$ 20M	$ 65M

This graph illustrates the flaw in the Payor Intervenors argument. They overlook the continuing effects of the previous years' savings. As DHA board member Jonathan Beal explained during the hearing, this situation is analogous to an increase in a union contract pay scale. A pay scale increase, as opposed to a one-time bonus, benefits the union employees not only in the year of implementation, but also in future years, ceteris paribus. Conversely, a pay scale decrease of $10 million will save the employer $10 million not only in the first full year of implementation, but also in future years as well, ceteris paribus.

The notion is not complex. It is familiar to any company or governmental entity that attempts to reduce a structural deficit in their annual budget or, conversely, to any persons who realize the wondrous effects of compounding interest on their investments.

Similarly, referring to the graph above, because the first two years of Dirigo-related cost savings lowered the base by $30 million dollars (the actual costs of $130 million was $30 million less than the $160 million projected costs for year 2) to which the 3rd year cost increase were applied, the total health care costs were still $20 million less than projected, notwithstanding that the cost increase in the 3rd year was $10 million more than expected. This is so, without double-counting any amount of cost savings.

D. The DHA Board's Determination of Uninsured Savings Initiatives Was Reasonable and Supported by Substantial Evidence in the Record

In its brief, the Dirigo Board refutes the assertions of the Payor Intervenors. However, the Board does not specifically refute a number of issues that the Payor Intervenors have raised. While CAHC agrees that the record amply supports the Boards determinations on these issues, and thus refutation of each and every issue is unnecessary, CAHC makes the following elaboration of the Board's position:

1. Payor Argument: The savings in bad debt and charity care as determined by the Board includes individuals who had DirigoChoice coverage for the time period covered by the Year 1 assessment, as well as during Year 2. The payors claim that to count these individuals toward the savings both in Year 1 and in Year 2 amounts to double-counting. *See* Trust Brief at 19; Anthem Brief at 26; MEHAP Brief at 30.

   CAHC Response: The Board included in the Year 2 savings those who obtained DirigoChoice in Year 1 and kept DirigoChoice coverage in Year 2. This was done because by continuing their coverage into Year 2 there is an avoided bad debt and charity care cost in Year 2. R. at 4984, 5005.

2. Payor Argument: The Board assumed that 61% of those joining Dirigo Choice were previously insured when the Muskie Study demonstrated that 72% were previously insured. MEAHP Brief at 30.

   CAHC Response: The Board did not rely upon the Muskie Study and instead relied upon an actual survey of DirigoChoice enrollees that reasonably supports the 61% assumption. R. at 4993, 5006.

3. Payor Argument: An HMBI of 9.2% was used. MEAHP Brief at 29; Chamber Brief at 43-44.

   CAHC Response: Payors fail to state what is wrong with this figure. The pre-filed exhibits, R. at 4982, state that this figure is derived from the hospital fiscal years ending in 2004. The 9.2 % increase reflects a 27-month period and therefore is not unreasonable or unsupported by the actual HMBI increase during the same period. R.at 4982.

4. Payor Argument: Mercer assumed that 50% of the bad debt and charity care was from the uninsured. Payors argue that the prior year submission of Dr. Kane supported only at 46% attribution. MEHAP claims that "Mr. Russell had no other documentation or independent analysis to support the use of the 50% assumption." MEAHP Brief at 29; Chamber Brief at 42-43.

   CAHC Response: Mercer's 50% assumption derived from the 4/15/05 presentation of the Maine Hospital Association. R. at 1096.

5. Payor Argument: The MaineCare "woodwork" effect is "entirely and utterly" speculative. MEHAP at 32.

   CAHC Response: The MaineCare "woodwork" effect is limited to counting only those 76 individuals who applied for DirigoChoice and were found to be eligible for MaineCare. R. at 4979. Since these 76 people sought health insurance through Dirigo

and not through MaineCare, their ultimate enrolment into MaineCare is clearly the result of Dirigo. CAHC fails to see why this is "entirely and utterly speculative."

6. Payor Argument: Mercer did not take into account that bad debt and charity care dropped $10 million from 2002 to 2003.

   CAHC Response: The $10 million drop is attributable to the initiation of the MaineCare non-categorical program in 2002 which provided MaineCare to those individuals whose incomes were below 100% of poverty and thus were eligible for charity care. R. at 70. (Testimony of John Shiels: "Those are people with pretty low incomes and they are likely to account for a fair amount of uncompensated care.")[3] In 2005, enrollment in the MaineCare program was frozen. MaineCare Eligibility Manual, Section 11000, 10-144 Chapter 332.

7. Payor Argument: Mercer failed to verify its bad debt and charity care amounts by using the Medicare cost reports. MEHAP Brief at 30.

   CAHC Response: Mercer used audited financial statements which are publicly available and show bad debt and charity care amounts. R. at 224. Therefore, it is not unreasonable to rely on audited financial statements.

8. Payor Argument: Mr. Russell "admitted that hospitals don't always pass on reductions in bad debt and charity care as reductions in charges."

   CAHC Response: The Dirigo statute only requires that aggregate measurable savings be measured, not passed on in the form of lower charges. Whether the savings get passed on is a function of negotiation. *See* Decision and Order of the Superintendent for First Assessment Year, p.8; 24-A M.R.S.A. §6913(7).

[3] This information is also found in the report of Dr. Nancy Kane. *See* Bad Debt and Free Care: Base Line Analysis Report, .5. This report was included in the Year 1 proceeding as Appendix I of the Final Report Submitted by the Dirigo Health Agency for the Year 1 assessment. This report is incorporated into the Year 2 record by virtue of the Payor Intervention's motion to include the entire Year 1 record into the Year 2 record.

9. Payor Argument: Mr. Russell provided no "documentation or independent analysis to support his more aggressive assumption in the growth of bad debt and charity care in the trend to bring the figure up to 2006." MEHAP Brief at 29.

   CAHC Response: The record supports the Mercer bad debt/charity care growth trend line. *See*, *e.g.,* R. at 5015 (Testimony of John Shiels).

10. Payor Argument: Mr. Russell relied on Dr. Kane's report but then failed to rely upon all of her assumptions. MEHAP Brief at 29.

    CAHC Response: Mr. Russell testified that Dr. Kane's study was "one of the reports we had available." R. at 4987.

In summary, the Board's decision on the uninsured initiatives is reasonably supported by the record.

E. The DHA Board's Determination of CON/CIF Was Reasonable and Supported by Substantial Evidence in the Record

Significant revisions to Maine's Certificate of Need Program were made by the Public Law 2003, Chapter 469, commonly referred to as the Dirigo Health Act. See Part C, P.L. 2003, Ch. 469 As stated above, the cost savings initiatives the Dirigo Health Agency Board measures and quantifies are not limited to bad debt and charity care and include the CON/CIF. The testimony of Cathy Cobb, Director of the Division of Licensing and Regulatory Services at the Maine Department of Health and Human Services provides ample support for the Board's inclusion of CON/CIF in their determination but also the methodology. She states:

Q. Could you please describe the CON/CIF process including any limitations for the 2005 --

A. For the 2005 period?

Q. Yes.

A. In 2005 it was the first year that a certificate of need was linked with the state health plan which was required under Dirigo and the capital investment fund that was established by the governor's Office of Health Policy.

The certificate of need process now must take into consideration the priorities of the state health plan and also the limitations under the capital investment fund. What that does is it takes certain projects that applicants submit and divides them up into different cycles that we review. We have cycles for large hospital projects, small hospital projects, non-hospital large and small projects. […]

Q. How does the CON/CIF process differ than the process prior to the Dirigo legislation?

A. Prior to Dirigo, we had a certificate of need act. We didn't have a state health plan and we didn't have a limitation on the amount of money that could be spent each year under the certificate of need. […]

Q. During the 2005 process, do you know of any of the hospitals that applied for CON and withdrew.

A. Yes.

Q. How many?

A. I believe four, at least four.

Q. Do you know what the basis was for their withdrawal?

A. Um, at least two of the projects were withdrawn because the applicants were able to get the projects, the capital expenditures and third year operating costs below the thresholds for review to avoid having to go through the CON process.

R. 5032

In short, the limits set by the CIF and the revised CON process resulted in applicants reducing the size and/or scope of the proposed projects in order to come in below the limits. The reduction of

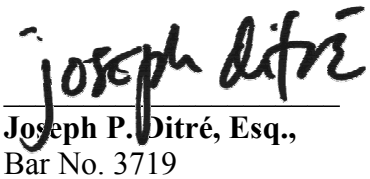
the size or scope of proposed CON projects produces savings system-wide that the Board reasonably and with ample support included in their determination of AMCS.

CONCLUSION

For all of the reasons stated above, the DHA Board's determination of AMCS, with the exception of the use of the median rather than the geometric mean to determine the rate of growth of the CMAD, is reasonable, supported by substantial evidence in the record, and upon review, should be accorded significant deference.

Dated: July 7, 2006

Respectfully submitted,



Joseph P. Ditré, Esq.,
Bar No. 3719

Counsel to

Consumers for Affordable Health Care
P.O. Box 2490, 39 Green Street
Augusta, Maine 04338-2490
Ph: 207-622-7045
Fax: 207-622-7077
Email: jditre@mainecahc.org

Jack Comart, Esq.
Maine Equal Justice
122 Sewall Street
Augusta, ME 04330
Ph: 626-7058
jcomart@mejp.org